H. Management contracts;

I. Medicare cost report, if applicable;

J. Review and compilation statement;

K. Statement verifying the restrictions as specified by the donor, prior to donation, for all restricted grants;

L. Working trial balance actually used to prepare the cost report with line number tracing notations or similar identifications; and

M. Schedule of capital assets with corresponding debt.

9. Cost reports must be fully, clearly and accurately completed. All required attachments must be submitted before a cost report is considered complete. If any additional information, documentation or clarification requested by the Division or its authorized agent is not provided within fourteen (14) days of the date of receipt of the Division's request, payments may be withheld from the facility until the information is submitted.

10. Under no circumstances will the Division accept amended cost reports for rate determination or rate adjustment after the date of the Division's notification of the final determination of the rate.

(B) Certification of Cost Reports.

1. The accuracy and validity of the cost report must be certified by the provider. Certification must be made by a person authorized by one (1) of the following: for an incorporated entity, an officer of the corporation; for a partnership, a partner; for a sole proprietorship or sole owner, the owner or licensed operator; or for a public facility, the chief administrative officer of the facility. Proof of such authorization shall be furnished upon request.

2. Cost reports must be notarized by a commissioned notary public.

3. The following statement must be signed on each cost report to certify its accuracy and validity:

Certification Statement: Misrepresentation or falsification of any information contained in this cost report may be punishable by fine and/or imprisonment under state or federal law.

I hereby certify that I have read the above statement and that I have examined the accompanying cost report and supporting schedules prepared by (provider name and number) for the cost report period beginning (date/year) and ending (date/year), and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Signature	Title	Date

(C) Adequate Records and Documentation.

1. A provider must keep records in accordance with GAAP and maintain sufficient internal control and documentation to satisfy audit requirements and other requirements of this plan, including reasonable requests by the Division or its authorized agent for additional information.

2. Each of a provider's funded accounts must be separately maintained with all account activity clearly identified.

3. Adequate documentation for all line items on the cost report shall be maintained by a provider. Upon request, all original documentation and records must be made available for review by the Division or its authorized agent at the same site at which the services were provided or at the central office/home office if located in the State of Missouri. Copies of documentation and records shall be submitted to the Division or its authorized agent upon request.

4. Each facility shall retain all financial information, data and records relating to the operation and reimbursement of the facility for a period of not less than seven (7) years.

*Substitute per letter dated SEP 23 1998

(D) Audits.

1. Any cost report submitted may be subject to field audit by the Division or its authorized agent.

2. A provider shall have available at the field audit location one (1) or more knowledgeable persons authorized by the provider and capable of explaining the provider's accounting and control system and cost report preparation, including all attachments and allocations.

3. If a provider maintains any records or documentation at a location which is not the same as the site where services were provided, other than central offices/home offices not located in the State of Missouri, the provider shall transfer the records to the same facility at which the Medicaid services were provided, or the provider must reimburse the Division or its authorized agent for reasonable travel costs necessary to perform any part of the field audit in any off-site location, if the location is acceptable to the Division.

4. Those providers initially entering the program shall be required to have an annual independent audit of the financial records, used to prepare annual cost reports covering at a minimum the first two (2) full twelve (12) month fiscal years of their participation in the Medicaid Program, in accordance with GAAP and Generally Accepted Auditing Standards. The audit shall include, but may not be limited to, the Balance Sheet, Income Statement, Statement of Retained Earnings and Statement of Cash Flow. For example, a provider begins participation in the Medicaid Program in March and chooses a fiscal year of October 1 to September 30. The first cost report will cover March through September. That cost report may be audited at the option of the provider. The October 1 to September 30 cost report, the first full twelve (12) month fiscal year cost report, shall be audited. The next October 1 to September 30 cost report, the second full twelve (12) month cost report, shall be audited. The audits shall be done by an independent certified public accountant.

(E) Change in Provider Status.

1. If a provider notifies, in writing, the Director of the Institutional Reimbursement Unit of the Division prior to the change of control, ownership or termination of participation in the Medicaid Program, the Division will withhold all remaining payments from the selling provider until the cost report is filed. The fully completed cost report with all required attachments and documentation is due the first day of the fourth month after the date of change of control, ownership or termination. Upon receipt of a cost report prepared in accordance with this plan, any payment that was withheld will be released to the selling provider.

2. If the Director of the Institutional Reimbursement Unit does not receive, in writing, notification of a change of control or ownership and a cost report ending with the date of the change of control or ownership, upon learning of a change of control or ownership, $30,000 of the next available full month Medicaid payment, after learning of the change of control or ownership, will be withheld from the provider identified in the current Medicaid participation agreement until a cost report is filed. If the Medicaid payment is less than $30,000, the entire payment will be withheld. Once the cost report, prepared in accordance with this plan, is received the payment will be released to the provider identified in the current Medicaid participation agreement.

(F) Joint Use of Resources.

1. If a provider has business enterprises in addition to the HIV nursing facility, the revenues, expenses, statistical and financial records of each separate enterprise shall be clearly identifiable.

2. When the facility is owned, controlled or managed by an entity or entities that own, control or manage one (1) or more other facilities, records of central office and other costs incurred outside the facility shall be maintained so as to separately identify revenues and expenses of, and allocations to, individual facilities. Direct allocation of cost, such as RN consultant, which can be directly identifiable in the central office/home office cost and directly allocated to a facility

by actual amounts or actual time spent. These direct costs shall be reported on the appropriate lines of the cost report. Allocation of central office/home office or management company costs to individual facilities should be consistent from year to year. If a desk audit or field audit establishes that records are not maintained so as to clearly identify information required by this plan, those commingled costs shall not be recognized as allowable costs in determining the facility's Medicaid reimbursement rate. Allowability of these costs shall be determined in accordance with the provisions of this plan.

(11) Cost Components and Per Diem Calculation. The Division will use the HIV nursing facility rate setting cost report.

(A) Patient Care. Each HIV nursing facility's patient care per diem shall be the lower of:

1. Allowable cost per patient day for patient care as determined by the Division from the rate setting cost report; or

2. The per diem ceiling of 120% of the patient care median determined by the Division from the databank.

(B) Ancillary. Each HIV nursing facility's ancillary per diem will be the lower of:

1. Allowable cost per patient day for ancillary as determined by the Division from the rate setting cost report; or

2. The per diem ceiling of 120% of the ancillary median determined by the Division from the databank.

(C) Administration. Each HIV nursing facility's administration per diem shall be the lower of:

1. Allowable cost per patient day for administration as determined by the Division from the rate setting cost report and adjusted for minimum utilization, if applicable, as described in Subsection (7)(O); or

2. The per diem ceiling of 110% of the administration median determined by the Division from the databank.

(D) Capital. Each HIV nursing facility's capital per diem shall be determined using the Fair Rental Value System as follows:

1. Rental Value.

A. Determine the total asset value.

(I) Determine facility size from the rate setting cost report;

(II) Determine the number of increased licensed beds after the rate setting cost report.

(III) Determine the bed equivalency for renovations/major improvements after November 30, 1995, by taking the cost of the renovations/major improvements divided by the asset value per bed for the year of the renovation/major improvement rounded to the nearest whole bed. The cost must be at least the asset value per bed for the year of the renovation/major improvement. For example, a renovations/major improvements cost of $200,000 is equal to 6 beds. ($200,000/ $32,723 equals 6.11 beds rounded to 6 beds);

(IV) Determine the number of decreased licensed beds after the rate setting cost report.

(V) Sum of (I),(II),(III) less (IV) times the asset value is the Total Asset Value.

B. Determine the reduction for age by multiplying the age of the beds by one percent (1%) up to forty percent (40%). For multiple licensing dates, the result of the weighted average age calculation will be limited to forty percent (40%).

(I) The age of the beds for multiple licensing dates is calculated on a weighted average method rounded to the nearest whole year. For example, a facility with original licensure in 1977 of 60 beds and an additional licensure of 60 beds in 1982 and 10 beds in 1993, the reduction is calculated as follows:

Licensure Year	Age	Beds	Age X Beds
1977	17	60	1020
1982	12	60	720
1993	1	10	10
Total		130	1750

Weighted Average Age - 1750/130 beds = 13.5 years rounded to 14 years. This results in a reduction for age of the beds of 14%.

(II) The age of the beds for replacement beds is calculated on a weighted average method rounded to the nearest whole year with the oldest beds always being replaced first. For example, a facility with 120 beds licensed in 1978 with replacement of 60 beds in 1988, the reduction is calculated as follows:

Licensure Year	Age	Beds	Age X Beds
1978	16	60	960
1988	6	60	360
Total		120	1320

Weighted Average Age - 1320/120 = 11 years. This results in a reduction for age of the beds of 11%.

(III) The age of the beds for reductions in licensed beds is calculated on a weighted average method rounded to the nearest whole year with the oldest beds always being delicensed first. For example, a facility with original licensure in 1977 of 60 beds, additional licensure of 60 beds in 1982 and 10 beds in 1993 and a reduction of 10 beds in 1985, the reduction percentage is calculated as follows:

Licensure Year	Age	Beds	Age X Beds
1977	17	60	1020
1982	12	60	720
1993	1	10	10
1985*	17	(10)	(170)
Total		120	1580

* reduction of 1977 beds

Weighted Average Age - 1580/120 beds = 13.2 years rounded to 13 years. This results in a reduction for age of the beds of 13%.

(IV) The age of the beds equivalents for renovations/major improvements is calculated on a weighted average method rounded to the nearest whole year. For example, a 120 bed facility licensed in 1978 undertakes two renovations: $200,000 in 1983 and $100,000 in 1993. The asset value per bed is $32,723. The bed equivalency is 6 beds for 1983 and 3 beds for 1993, the reduction percentage is calculated as follows:

Licensure/ Construction Year	Age	Beds	Age X Beds
1978	16	120	1920
1983	11	6	66
1993	1	3	3
Total		129	1989

Weighted Average Method - 1989/129 = 15.42 years rounded to 15 years. This results in a reduction for age of beds of 15%.

C. The facility asset value is subparagraph (11)(D)1.A. less subparagraph (11)(D)1.B.

D. Multiply the facility asset value by two and one-half percent (2.5%) to determine the rental value. The two and one-half (2.5%) is based on a forty (40) year life.

E. The following is an illustration of how subparagraphs (11)(D)1.A., (11)(D)1.B. and (11)(D)1.C., (11)(D)1.D. determines the rental value:

(I) Total Facility Size - 174 beds
Weighted Average Age of the Beds - 23 years
Capital Asset Debt - $2,371,094
Asset Value - $32,723

(II) The Total Asset Value is the product of the Total Facility Size times the Asset Value;

Total Facility Size	174
Asset Value	X $32,723
Total Asset Value	$5,693,802

(III) Facility Asset Value is Total Asset Value less the Reduction for Age of the Beds; and

Reduction for Age (23%)	$1,309,574
Facility Asset Value	$4,384,228

(IV) Rental Value is the Facility Asset Value multiplied by 2.5%.

	X 2.5%
Rental Value	$ 109,606

2. Rate of Return.

A. Reduce the Facility Asset Value by the Capital Asset Debt, but not less than zero, times the percentage of return. The percentage of return is the yield for the thirty (30) year Treasury Bond as reported by the Federal Reserve Board and published in the *Wall Street Journal* for the week ending June 30, 1995, plus two percentage (2%) points. The rate is 6.58% for the week ending June 30, 1995, plus 2% for a total of 8.58%.

B. The debt associated with increases in licensed beds or renovations/major improvements after the end of the facility's rate setting cost report and will be added to the capital asset debt from the rate setting cost report. The facility shall provide adequate documentation to support the additional debt as required in paragraph (7)(E)2. If adequate documentation is not provided to support the additional asset debt, it will be assumed to equal the facility asset value.

C. The following is an illustration of how subparagraph (11)(D)2.A. is calculated:

Facility Asset Value	$4,331,573
Capital Asset Debt	$2,371,094
	$1,960,479
Percentage of Return	X 9.48%
Rate of Return	$ 185,853

3. Computed Interest and Pass Through Expenses.

A. Add property insurance (line 107) and property taxes (lines 108 and 109). Also add interest subject to limits identified in subsection (7)(F). These lines are found in the cost report, version MSIR-1 (3-95).

B. The following is an illustration of how subparagraphs (11)(D)3.A. is calculated:

Computed Interest	$ 207,840
Insurance	$ 7,594
Property Taxes	$ 40,548
Pass Through Expenses	$ 48,142

4. Capital Component Per Diem Calculation.

A. A per diem is calculated by dividing the sum of rental value, rate of return and computed interest by the number of beds determined in subparagraph (11)(D)1.A. times 365 adjusted by the greater of the minimum utilization as determined in subsection (7)(O) or the facility's occupancy from the rate setting cost report. The following is an illustration of how subparagraph (11)(D)4.A. is calculated: